

Medicaid Cancer Program



January 2005

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Health Policy Manual A, B, D - Section 319

PACMIS Program type: DM
 Category code: W
 Coverage code: Blank or E for emergency services

 SSDO screen: Enter "C" in Disability Code field.

The Medicaid Cancer Program provides Medicaid coverage women who qualify. It provides full Traditional Medicaid benefits, not just services for the treatment of cancer.

The eligibility criteria is:

1. Must be a woman.
2. Must be under age 65.
3. Must not be eligible for any other Medicaid program.
4. Has no creditable health insurance coverage.
5. Must be screened for breast or cervical cancer under a CDC (Center for Disease Control) provider and Cervical Cancer Early Detection Program. The UCCP (Utah Cancer Control Program) is the CDC provider who completes the screening.
6. The UCCP screening must identify woman to be in need of treatment for breast or cervical cancer. This includes precancerous conditions and early stage cancer.

A woman with another type of cancer meets this requirement when the primary site of her cancer (the place where the cancer originated) was breast or cervical cancer. When the primary site of the cancer was somewhere other than the breast or cervix, a woman does not meet the requirement for this program.

Note: UCCP also determines income eligibility which must be under 250% of Federal Poverty level.

The program is located at the following address:
Utah Cancer Control Program
228 North 1460 West
P.O. Box 142107
SLC, Utah 84414-2107
1-800-717-1811



Workers can call the UCCP staff directly.
Have the customer's name and phone number ready.
Do not give these phone numbers to the customer:

Maritza	801-538-6990
Shellee	801-538-6491

UCCP Referral

When a woman is screened for breast or cervical cancer under the CDC Breast and Cervical Cancer Early Detection Program (UCCP) and found to be in need of treatment, UCCP will complete and sign a Medicaid Cancer Program Referral (Form 928). The Form 928 must be received by the Medicaid worker before the case can be approved.

When the woman meets with the Utah Cancer Control Program (UCCP) representative, the representative will:

1. Verify that the woman was diagnosed with breast or cervical cancer.
 - ✓ The original date (the date the pathology report shows she is positive for cancer) can be no earlier than April 1, 2001.)
 - ✓ It must be done by a CDC contracted provider.
 - Women who move to Utah meet this requirement if they were diagnosed by a CDC provider in another state and were found to need treatment from breast or cervical cancer. Verify the screening.
2. Verify that there is a need for treatment for the breast or cervical cancer
 - ✓ This includes diagnostic services to determine the course of treatment, and
 - ✓ Precancerous conditions (entitles a woman to three months of eligibility under the Medicaid Cancer program beginning with the month of diagnosis).
3. Determine income eligibility for the program.
 - ✓ The income limit for the program is 250% of Federal Poverty.
4. If eligible, UCCP will give the customer a Form 928 referral to submit with their Medicaid application.
 - ✓ If the woman has already submitted a Medicaid application, the UCCP case manager will fax a completed form to the Medicaid worker with the eligibility results of the woman's screening.

What if the Woman Has Cancer But We Don't Have a Referral from UCCP?

If our customer indicates they have breast or cervical cancer, and this was diagnosed by someone other than a CDC contracted provider, refer the woman to UCCP to be screened for the Medicaid Cancer Program.

BES Form 928

September 04

MEDICAID CANCER PROGRAM REFERRAL FORM

Date Sent to Medicaid _____

Date sent to UCCP _____

Name: _____ SSN: _____

D.O.B. _____ Phone Number: _____

Address: _____

City County State Zip

Annual Household Income: _____ Family size: _____

Health Insurance: ☐ Yes ☐ No

☐ This individual has been screened and found to be in need of treatment for breast/cervical cancer by a contracted provider of the Utah Cancer Control Program.

☐ This individual has been screened and found to be in need of treatment for pre-cancerous conditions for breast/cervical cancer (entitles a woman to three months of eligibility under the Medicaid Cancer program beginning with the month of diagnosis).

Signature & Phone Number of UCCP Case Manager Date

This person is ☐ eligible ☐ not eligible for Medicaid benefits.

Effective date of Medicaid Eligibility: _____

Eligibility is for which Medicaid Program? (Specify if the client is under the Medicaid Breast and Cervical Treatment Act-Medicaid Cancer Program): _____

If not eligible for Medicaid, list reason: _____

Signature & Phone Number of Medicaid Worker Date

Important: Please **fax this form back** to UCCP as soon as it has been completed. Thanks!
Fax: 801-538-9495

INSTRUCTIONS FOR FORM 928
MEDICAID CANCER PROGRAM REFERRAL FORM

PURPOSE: To receive coverage under the Medicaid Cancer Program, an individual must be identified through a contracted Center for Disease Control and Prevention (CDC) provider as needing treatment for breast or cervical cancer. In Utah, this provider is the Utah Cancer Control Program (UCCP). The form 928 is used to verify that an individual meets this requirement.

PREPARATION: UCCP Case Manager

The UCCP case manager completes the top portion of the form. They fill in the name, SSN, DOB, address, phone number, and annual household income of the individual. The UCCP case manager signs, enters their phone number, and dates the form verifying that the individual has been screened and found to be in need of treatment for breast or cervical cancer or has been screened and found to be in need of treatment for pre-cancerous conditions for breast/cervical cancer by a contracted provider of the UCCP. The date the referral form is being sent to Medicaid is then completed. UCCP retains a copy of the 928 Form.

If the woman has not yet made a Medicaid application, the UCCP case manager will give her the 928 Form verifying she has been screened by a CDC provider along with a Medicaid application. The woman will present these two forms to the Medicaid office.

If the woman applied for Medicaid prior to her UCCP screening, the UCCP case manager will fax a completed form to the Medicaid worker.

Medicaid Case Manager

The Medicaid eligibility worker completes the bottom portion of the form marking the box stating whether the person is eligible or ineligible for Medicaid. If eligible, the Medicaid worker lists the effective date of the Medicaid eligibility and the Medicaid program type the individual is eligible for. (ie: Medicaid Cancer Program, Family Medicaid, etc.). If not eligible, the Medicaid worker lists the reason the person is not eligible. The Medicaid worker signs, enters their phone number and dates the form. The Medicaid worker must notify UCCP of the woman's eligibility by entering the date in the box at the top right hand side of the form and faxing it back to UCCP. The original copy of the form is filed in the case folder.

Worker Responsibilities

Once we receive a Medicaid application and a referral from the UCCP (Form 928), take the following actions:

1. Determine if there is another Medicaid program appropriate for the woman.
If there is possible eligibility for another program:
 - A. Verify factors of eligibility for that Medicaid program.
 - 1) If it is clear that the applicant does not meet the requirements for any other Medicaid program, only request verifications needed to determine eligibility for the Medicaid Cancer Program.
 - 2) If requested verifications needed to decide eligibility for a different Medicaid program are not provided, deny coverage for the Medicaid Cancer program.
 - B. When a woman meets eligibility for another program, open that program rather than the Medicaid Cancer Program.

A woman is not eligible for the Cancer program if they qualify for another Medicaid program.

Exception: If the woman must pay a spenddown, premium, or asset co-payment to qualify for the other Medicaid program, they can choose the Medicaid Cancer Program.

2. If the woman is not eligible for any other Medicaid program, before opening the Cancer Program:
 - A. Verify factors of eligibility for Medicaid (except income and assets).
Factors of eligibility include:
 - 1) Citizenship and residency
 - 2) Age - under age 65
 - 3) Social Security number
 - 4) No creditable health insurance
 - 5) TPL
 - 6) Provider choice
 - 7) Referral Form 928 from UCCP

Exceptions

- 1) There are no Duty of Support requirements.
However, a woman who is sanctioned from Medicaid coverage (a program other than the Cancer Program) for failure to comply with Duty of Support or Third Party Liability is not eligible for the Medicaid Cancer Program.
- 2) There is no asset limit.

3. If eligible, open the Medicaid Cancer Program setting a 12 month review period.
4. Complete the Form 928 and fax it back to UCCP. Indicate the action taken on the referral including the Medicaid eligibility decision. Keep a copy of the 928 form in the case folder.
5. If the woman applies for Medicaid and appears eligible for the Medicaid Cancer Program, but she does not have a Form 928 referral form, refer the customer to the UCCP.



UCCP needs to know the application decision.
Don't forget to complete the 928 form
and fax it back to UCCP.

"Creditable Health Insurance Coverage"

A woman is not eligible for this program if she has other health insurance that will cover her treatment needs for breast or cervical cancer, or both, or a pre-cancerous condition, if applicable. This is considered "creditable health insurance coverage."

Exception: If the plan does not provide coverage for breast or cervical cancer she can be eligible for the program.

Examples of when a person who has Group Health Insurance is eligible:

1. Pre-existing conditions that will not cover her due to an exclusion period.
2. Woman has exhausted her benefits under the plan.

A woman enrolled in any of the following types of health insurance is not eligible for the Cancer Program because she is considered to have "creditable coverage".

1. Group Health Plan - Health insurance plan provided by an employer.
2. Health Insurance Coverage or Plan - This is insurance through a hospital or medical service plan contract or health maintenance organization contract. It may be a group or individual plan.
3. Medicare
Note: A woman who is eligible for Medicare is not eligible for the Medicaid Cancer program even if she has not enrolled in Medicare.
4. Medicaid
Exception: If the woman must pay a spenddown, premium, or asset co-payment to qualify for Medicaid, she can be eligible for the Cancer Program.
5. Armed Forces Insurance.
6. Indian Health Service (IHS) or AI/AN Tribal Organizations
Note: Woman must have access to coverage.
7. State Health Risk Pool.

Note: A woman open on the Medicaid Cancer program is no longer eligible if she enrolls in a group health plan or other health insurance coverage that will cover treatment for breast or cervical cancer.

Exceptions:

A woman who has health insurance can receive the Cancer Program if:

1. Insurance does not cover treatment of breast or cervical cancer, or
2. Her insurance does not cover her treatment because it is considered a "pre-existing condition", or
3. She has exhausted her lifetime maximum for benefits under the plan.

A woman meets eligibility for this program because the insurance would not be considered to be "creditable" health insurance coverage.

Available Coverage Under a Health Plan

A woman does not have to enroll in a health insurance plan, even if it is available to her.

Exception: A woman who is eligible to enroll in Medicare but has not enrolled, is not eligible for the Medicaid Cancer Program.

Termination of Coverage

Once a woman's creditable health insurance terminates, she can immediately be eligible for the Medicaid Cancer program.

There is no sanction if she drops her health insurance.

Age Requirement

Age Limit: Under age 65. A woman is eligible the month she turns age 65.

TPL Requirements

TPL information must be provided if the woman has insurance, even though the insurance does not cover treatment for her breast or cervical cancer.

TPL form is not required if no insurance is claimed.

Provider Choice Requirements

The customer must choose a primary provider.

Program Benefits

If eligible for this program the woman is entitled to full Traditional Medicaid benefits. Coverage is not limited to the treatment of breast or cervical cancer.

Pre-cancerous condition diagnosis - maximum of three months of coverage.

Date of Entitlement (See 611-1)

Eligibility starts from the first day of the application month unless one of the following criteria is true. The woman:

- ✓ Moved to Utah to take up residency during the application month. Case eligibility cannot begin before the date she arrived in Utah. OR
- ✓ Is a qualified alien who was subject to the five-year bar for Medicaid and the five years ended during the application month. Case eligibility cannot begin before the date the five year bar ended. OR
- ✓ Became a qualified alien who is not subject to the five-year bar during the application month. Case eligibility cannot begin before the date she became a qualified alien.

Note: DM-W allows emergency services for non-qualified aliens.

Retroactive Assistance

The retroactive period is three months preceding the date of the application and cannot begin prior to July 1, 2001 (when the program started).

The effective date cannot be earlier than the date in the third month before the application month that matches the date of application.

Example: A woman applies on July 15, her eligibility cannot begin earlier than April 15.

Eligibility cannot begin before the date the woman was screened for and diagnosed with breast or cervical cancer.

Eligibility Period

Diagnosed with Breast or Cervical Cancer

Once the woman is eligible for the Cancer program, continue eligibility until the next review.

If she reports a change, take action on the reported change to determine continued eligibility. Close the case if the change makes her ineligible.

When a change is reported, determine if she is eligible for another Medicaid program. If she is, close the Cancer Medicaid program and open the appropriate Medicaid program.

- ✓ 10 day notice is required if she will no longer receive Traditional benefits on the other Medicaid program.

If she requests her case to be closed, close the case.

Diagnosed with a Pre-Cancerous Condition

The eligibility period for a woman who is diagnosed with a pre-cancerous condition is limited to two full calendar months of coverage after the month benefits become effective, for a maximum of three months of coverage.

- ✓ Begin eligibility with the month the woman was diagnosed with a pre-cancerous condition, (as long as she applies within three months of the diagnosis).
- ✓ End eligibility at the end of the second month after the month of diagnosis, for a total of three months of eligibility.

Continue to the next page for PACMIS Procedures





Precancerous Diagnosis PACMIS Procedure:

Once a case is approved, authorize eligibility and Medicaid cards for all three benefit months and then manually close the case.

1. Approve and authorize DM-W the same month the woman was diagnosed with a precancerous condition.
2. Copy the case forward to the next month and authorize the second month of DM-W eligibility and Medicaid card.
3. Copy the case forward to the next month and authorize the third month of DM-W eligibility and Medicaid card.
4. Copy the case forward to the next month (fourth month after approval month) and close the DM-W case.



Go to the DMED screen and enter the 'PT' closure code.

5. Complete and send the MMPT notice.

```
NODT          LIST NOTICE DEFINITION TABLE          10Nov04 10:23
NOTICE: MMPT    NUMBER OF LINES 26      PAGE: 1      CAROLYN
EFFECTIVE DATE FROM: 01AUG04 EFFECTIVE DATE TO: 9999999
TITLE: APPROVE 3 MOS/CLOSE PRE-CANCER TREATMENT
>>
YOUR APPLICATION FOR THE MEDICAID CANCER ASSISTANCE PROGRAM DATED  @@
%%%%%%%%%%%%%%%%%%%%%%%%% HAS BEEN APPROVED EFFECTIVE %%%%%%%%%%%%%%%%%%%%%%%%%%. @@
>>
YOUR ELIGIBILITY FOR MEDICAL COVERAGE IS BASED ON YOUR NEED FOR
TREATMENT OF A PRE-CANCEROUS CONDITION AND IS LIMITED TO THREE MONTHS
OF MEDICAID ELIGIBILITY. THE COVERAGE BEGINS WITH THE MONTH OF
DIAGNOSIS AND CONTINUES FOR TWO ADDITIONAL MONTHS. YOU WILL RECEIVE
MEDICAL COVERAGE FOR THE MONTHS OF %%%%%%%%%%%%%%%%%%, %%%%%%%%%%%%%%%%%%, AND
%%%%%%%%%%%%%%%%%. YOUR MEDICAID CANCER ASSISTANCE CASE WILL BE CLOSED
EFFECTIVE %%%%%%%%%%%%%%%%%%%%%%%%%%.@@
>>
YOU WILL RECEIVE A MEDICAL CARD IN THE MAIL FOR EACH MONTH. YOU MUST
SHOW THIS CARD TO THE DOCTOR, PHARMACY, OR HOSPITAL TO GET MEDICAL
COVERAGE.@@
>>
WE HAVE LOOKED AT ELIGIBILITY UNDER ALL CURRENT MEDICAL PROGRAMS.
CONTINUE (Y OR N): Y
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NODT          LIST NOTICE DEFINITION TABLE          09Nov04 17:50
NOTICE: MMPT    NUMBER OF LINES 5      PAGE: 2      CAROLYN
EFFECTIVE DATE FROM: 01AUG04 EFFECTIVE DATE TO: 9999999
TITLE: APPROVE 3 MOS/CLOSE PRE-CANCER TREATMENT
HOWEVER, IF YOU HAVE BECOME DISABLED, PREGNANT, OR THERE HAVE BEEN
OTHER CHANGES IN YOUR HOUSEHOLD CIRCUMSTANCES, PLEASE CONTACT YOUR
LOCAL OFFICE.@@
>>
IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CALL US AT
%%%%%%%%%%%%%%%%%%%%%%%%%. COLLECT CALLS WILL BE ACCEPTED.@@
>>
THIS ACTION IS BASED ON VOLUME IIID SECTION 319-2.@@
>>
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Eligibility Reviews

The Medicaid Cancer program review period is every 12 months. Renew eligibility for another 12 months if the woman completes the review, verifies that she is still in need of treatment, and continues to meet other eligibility criteria.

The review consists of the following:

The Medicaid Cancer Program has its own review, Form (61C).

1. PACMIS will automatically mail a 61C Review Form to the woman the month before the review month.
 - ✓ A review due date does not display on CAP2. The benefit effective date is used to determine when the annual review should be sent.
 - ✓ DM-W reviews are not affected by the review dates of other programs that might be open on the case.
2. The woman should complete the required fields on the review form. Question #1 asks if the woman has health insurance coverage for breast and/or cervical cancer.
 - ✓ If she does, then she only needs to complete this question and return the form to her Medicaid worker. She is no longer eligible for the Medicaid Cancer program.
 - ✓ If the woman does not have health insurance coverage for breast and/or cervical cancer, then she should continue to question #2 on the review form.
3. Question number #2 on the review form explains that a doctor needs to verify that she is still in "need of treatment" for breast or cervical cancer.
 - ✓ The woman is instructed to complete the personal information on the other side of the 61CR Form, then to take the form to her doctor.
4. The term "need treatment" is defined for the doctor on the form. The doctor will mark whether or not the woman is still in "need of treatment", sign the form, and return the 61CR Form to the woman.
5. The woman will return the completed form to her worker by the date shown on the form. There is no client signature required.
6. A telephone review can only be completed if the woman now has health insurance coverage that covers breast and/or cervical cancer. Otherwise, the review form must be returned to the office. This is because of the required doctor's statement.
7. The DM-W case will auto-close if the review is not completed and returned by the due date.

Woman Completes and Returns Review Form 61C

Determine if she is still eligible for the program. The woman must meet the following criteria:

1. Doctor statement verifies she still needs treatment, and
2. Does not have creditable insurance coverage,
3. Meets the age requirement.

Assume that other eligibility factors have not changed unless other changes are reported.

- ✓ If so, decide whether she could be eligible for another Medicaid program.
- ✓ If not, complete the review for the Cancer Program.

If the woman does not meet the criteria, close the case.

Woman Does Not Complete and Return Review Form 61C

- ✓ DM-W case will auto-close if the review is not completed by the due date.

Completed Review Form is Returned After Auto-Closure

If the completed review form is returned:

- ✓ By the end of the review month or by the end of the following month, redetermine the woman's eligibility. If eligible, revert the case to open and renew eligibility without interruption.
- ✓ The second month after the review month, or later, treat it as a new application. Consider retroactive months.
 - A new UCCP referral is not required.

Review for Other Programs

If the woman has a review for other programs and is no longer eligible or does not complete that review:

- ☺ The Cancer Program remains open. The review from other programs does not affect eligibility for the Cancer program.



Cancer Review Form:

<http://health.utah.gov/eol/forms/pdffiles/61cr.pdf>

Instructions for the Cancer Review Form (61CR):

<http://health.utah.gov/eol/forms/instructions.htm#61cr>

PACMIS Procedures for DM-W Reviews

PACMIS will mail the review the month before the review month.

- ✓ Mail date is displayed on the RERE screen under DM/W print date (DM/W PR DATE).
- ✓ A "Y" displays in the REV DUE field to the right.
 - "Y" indicates a review is due and has not been returned.

Completed review is returned and woman remains eligible:

1. Go to the RERE screen and blank out the "Y" in the REV DUE field.
2. Copy to the next month.
3. Work the review and authorize through current PACMIS month.

Completed review is returned and woman is no longer eligible:

1. Go to the RERE screen and blank out the "Y" in the REV DUE field.
2. Copy to the next month.
3. Close case on DMED using the 'ZZ' closure code.
4. Send review closure notice GCZZ , complete reason for closure (ie: is no longer in need of treatment) and list policy reference.
5. Document closure reason on CAAL.

Review is not returned:

Take no action, DM-W will auto-close the end of the month following the month it was mailed.

- ✓ Auto-closure removes the "Y" on RERE. The worker does not need to removed the "Y" if reinstating case after auto-closure has run.

RERE Screen

```
RERE                                REGISTER REVIEW                        16SEP04 17:51
                                      JANET T
CASE NAME: FQ2, REVIEW TEST          CASE NUMBER: 00032958
PRIMARY DEP/RG/OFF: HCC TEAM: 1 CASELOAD: 10 - TAYLOR, JANET

PROGRAM INVOLVEMENT :   DM           AM
APP RECEIVED DATE   : 03NOV03   01AUG04
BEN EFFECTIVE DATE   : 01NOV03   01AUG04
PROGRAM STATUS       :    OP           OP

PREVIOUS REV        : AUG04   ADDRESS INFO?(Y/N): Y
REVIEW DUE DATE     : DEC04   INTERVIEW DATE: 01AUG04   INTERVIEW TYPE:

REVIEW  MOD  PRINT  TYPE OF      CI REVIEW FORM PC REVIEW  DM/W    REV
DATE    TYPE DATE  REVIEW FORM  PRINT DT  REQD PRINT DATE PR DATE DUE
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D                                16SEP04  Y
01AUG04  F
03NOV03  F
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NEXT-->

Length of Eligibility

The woman is no longer eligible for the Cancer program if:

1. Treatment is completed, or
2. Doesn't meet program requirements; such as, age or lack of insurance.

Changes

If a customer reports a change, take action on the reported change.

Changes that could cause the Cancer Medicaid case to close are:

1. Woman leaves Utah (not temporary absence).
2. Reaches age 65.
3. Enrolls in a creditable Health Insurance plan that covers breast or cervical cancer.
4. Becomes eligible to enroll in Medicare.
5. No longer needs treatment for breast or cervical cancer.
6. Becomes eligible for another Medicaid program.
 - ✓ Close the Medicaid Cancer Program and open the woman on the other Medicaid program.
7. Woman dies.

Case Closures

Close the case when:

- A. She is no longer eligible for the program, or
- B. She requests her case to be closed.

Emergency Services

Emergency Medical for this program is allowed if the woman meets all criteria except citizenship or qualified alien criteria.

PACMIS: PACMIS Program: DM
 Category Code: W
 Coverage Code E

Regular treatment is not an emergency need, however breast or cervical cancers may be identified in various stages. Some women in need of treatment for breast or cervical cancer will have an emergency condition.

Emergency cases should be opened for one or two months to provide coverage of the emergency, then closed.

If the woman indicates that they do not have a continued emergency need, close the case.

Keep the case open if she says she has a continued emergency need. The Health Department representative will review the bills to determine if the bills are for an emergency need. The bill will not be covered if it is not an emergency.

For additional information on this program, go to the Department of Health/BES Website:

<http://health.utah.gov/eol/>

Click on:	Training
Choose:	Slide Shows
	Medicaid Cancer Program